431-1
The CDHS has instructed the counties in the implementation of the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act (MCCA) of 1988 relating to property. (All-County Welfare Directors Letter (ACWDL) No. 90-01, January 5, 1990) The CDHS has set forth the income provisions of MCCA. (ACWDL No. 90-03, January 8, 1990) There are currently no state regulations implementing MCCA as of December 1, 2002.

431-2
Federal law defines an institutionalized spouse as an individual in a medical institution or nursing facility (and who is likely to meet this requirement for 30 consecutive days) and is married to a spouse who is not in a medical institution or nursing facility. A community spouse is the spouse of the institutionalized spouse. (42 United States Code (USC) §1396r-5(h))

For purposes of MCCA a couple is married until that marriage is dissolved or annulled. A legal separation will entitle the two spouses to the Community Spouse Resource Allowance plus the property limit for one, and for income allocation to the community spouse. (All-County Welfare Directors Letter (ACWDL) No. 91-55, June 11, 1991)

431-3 REVISED 12/05
An institutionalized spouse may transfer an amount equal to the Community Spouse Resource Allowance (CSRA), but only to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. Such transfer shall not be disqualifying. The CSRA, as defined in Subsection (f)(2) is the greatest of four calculations. In California, the second option, $60,000 plus an indexed figure, is used. (42 United States Code §1396r-5(f)(1))

The CSRA is $99,540 in 2006. (All-County Welfare Directors Letter (ACWDL) No. 05-40).

431-4 REVISED 12/05
The Minimum Monthly Maintenance Needs Allowance (MMMNA) as set forth in 42 USC §1396r-5(d)(3)(C) shall not exceed $1,500, subject to adjustment under Subsections (e) and (g).

Subsection (g) provides for an indexing of the $1,500. Subsection (e)(2)(B) provides that if either spouse establishes that the community spouse needs income, above the level otherwise provided by the MMMNA, due to exceptional circumstances resulting in significant financial duress, there shall be substituted an amount adequate to provide such additional income as is necessary. Such revised MMMNA is to be resolved at the state hearing provided applicants or recipients. (42 USC §1396r-5(e)(2)(B))

The basic MMMNA is $2489 effective January 1, 2006. (All-County Welfare Directors Letter No.05-40)

431-5
Under federal law, if either spouse establishes that the CSRA, in relation to the amount of income generated by such an allowance, is inadequate to raise the community spouse's income to the Minimum Monthly Maintenance Needs Allowance (MMMNA),

there shall be substituted for the CSRA under Subsection (f)(2) an amount adequate to provide such an MMMNA. (42 United State Code §§1396r-5(e)(2) and (f)(2))

431-6
Pursuant to a policy clarification from the Health Care Finance Administration, a deposit of a Long Term Care (LTC) spouse's income into a joint account is considered a transfer of income to the spouse at home. In joint bank account situations, no further verification is necessary. However, when income is not deposited in a joint account, the beneficiary must provide documentation that the monies actually changed hands, via a canceled check, bank statement, etc. (All-County Letter Welfare Directors (ACWDL) No. 90-89, October 9, 1990)

431-7
Federal law provides for allowances to be offset from the income of an institutionalized spouse. After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to the payment for the cost of the care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance;

(B) A community spouse monthly income allowance, but only to the extent income of the institutionalize spouse is made available to or for the benefit of the community spouse;

(C) A family allowance, for each family member, equal to at least one-third of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member; and

(D) Amount for incurred expense for medical or remedial care for the institutionalized spouse.

This section goes on to say that the term “family member” only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(42 United States Code (USC) §1396r-5(d)(1))

431-8 REVISED 12/05
The CDHS has not issued regulations as of December 1, 2005, to implement the Federal Statutes governing MCCA. However, in All-County Welfare Directors Letter (ACWDL) No. 90-03, January 8, 1990, proposed regulations were set forth.

Proposed §50563.5 provides that when an aged, blind, or disabled person with LTC status has a community spouse residing in the home, the income of the person with LTC status shall be treated as follows:

(1) Determine the gross nonexempt income of the person with LTC status which is in excess of the appropriate maintenance need for that person and in accordance with the provisions of §50605;

(2) Determine the maintenance need for the community spouse in accordance with §50605(f)(1), and deduct from that maintenance need the total gross monthly income of the community spouse, with the remainder being the community spouse allowance;

(3) Determine the maximum allocation base for each family member in accordance with §50605(f)(2), and deduct from this allocation base the gross monthly income of that family member. One-third of the remainder shall be considered the family member allowance for that person. The total of all family member allowances shall be considered the total family member allowance; and

(4) Add the community spouse allowance with the total family member allowance. This is the amount which shall be allocated to the community spouse and other family members from the income amount for the person with LTC status.

Exceptional circumstances that result in financial duress shall include, but are not limited to, costs associated with the purchase of housing modifications to the extent the community spouse maintenance need is inadequate to cover such purchases; costs associated with the ongoing purchase of prescribed medical diet foods and dietary supplements; utility costs associated with the use of prescribed medical equipment to the extent the community spouse maintenance need is inadequate to cover such costs; repairs necessary to maintain the home in a liveable condition, which shall not include optional or cosmetic changes; and unusual and unforeseeable circumstances such as fire, flood, or other special circumstances which result in loss of normal housing, clothing, household goods, and other necessary possessions. (Proposed §50605.5(c))

Exceptional circumstances resulting in financial duress shall not include the usual increases for rent, food, housing, clothing, and other customary living expenses. (Proposed Subsection (d))

Once a finding of exceptional circumstances resulting in financial duress has been established, the state ALJ shall establish a new maintenance need for the community spouse which shall include an amount sufficient to cover such expenses, and specify whether such maintenance need level will be temporary or continuing. If the order specifies that the maintenance need is temporary, the ALJ shall establish the duration of the new maintenance need and advise the claimant that he/she must request an extension through the state hearing process if the exceptional circumstance continues. The CDHS has issued tables which set forth the community spouse maintenance need, as set forth above. In 200_, that maintenance need standard is $_____. CDHS has also issued an allocation base, for attribution of income from the LTC family member to the other family members. For _____ persons, that allocation base is $_____. (Proposed Subsection (f); All-County Welfare Directors Letters (ACWDLs) No. _____)

431-8A REVISED 12/05

The family-member maximum base allocation amount is used to determine how much income the long-term care beneficiary may allocate to family members. Effective July 1, 2005 through June 30, 2006, the family member maximum base allocation is $1604. (All

County Welfare Director's Letter ACWDL 05-20, June 14, 2005)

431-8B ADDED 5/05
Where there are minor children in the home but no community spouse and there is a parent in LTC; or where a person in board and care or a medically indigent adult in LTC has a spouse and/or children living in the home, the existing allocation methodology will continue to apply. The family's net nonexempt income will be deducted from the maintenance need for a family of appropriate size with the remainder allocated to the family living in the home. (ACWDL 90-03, January 8, 1990)

431-9
"Spousal impoverishment" rules for determining the property eligibility of, and allocating income from, an institutionalized spouse with a community spouse will be applicable in situations where one spouse is enrolled in a Program for All Inclusive Care of the Elderly (PACE) (the "institutionalized" spouse) and the other spouse is not (the community spouse).

These rules will generally apply effective July 1, 1997. Notifications of PACE participation must have the spousal impoverishment rules applied by the first of the second month following notification to the county. (All-County Welfare Directors Letter (ACWDL) No. 97-18, May 12, 1997)

431-9A
Counties are required to notify identified continuing PACE cases (existing only in Alameda, Sacramento, and San Francisco counties in May 1997): (1) as to the Community Spouse Resource Allowance (CSRA) transfer period; (2) that at the end of the CSRA transfer period the institutionalized (PACE) spouse's name may appear on no more than $2000 worth of countable, nonexempt property; and (3) that the community spouse may retain the remainder up to the maximum CSRA.

The PACE spouse shall be treated as institutionalized, even when residing in the home of the community spouse who is not enrolled in PACE and who otherwise meets the definition of a community spouse.

(All-County Welfare Directors Letter No. 97-18, May 12, 1997)

432-1
To be eligible as a Qualified Medicare Beneficiary (QMB) individual, one must be entitled to Part A Medicare hospital insurance benefits; meet the qualifying income level, as defined in §50570; and meet the qualifying resource limit, as defined in §50421. (§50258(a))

Eligibility for the QMB Program shall begin the first of the month following the month of approval. (§50258(b))

CDHS shall pay Medicare premiums, coinsurance, and deductibles. (§50258(c))

432-2
Federal law defines a "qualified Medicare beneficiary" as an individual who is entitled to hospital insurance benefits under Part A of Subchapter XVIII; whose income does not

exceed the official poverty line for a family of such size; and whose resources do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under the SSI Program. Such individuals are eligible to receive, from the state, certain premiums under Subchapter XVIII (including Parts A and B), deductibles and coinsurance fees. (42 United States Code §1396d-p)

The CDHS policy as to implementation of this program is set forth in All-County Welfare Directors Letter (ACWDL) No. 90-02, January 8, 1990; Medi-Cal Eligibility Procedures Manual (MEPM) 5F, issued as part of ACWDL No. 91-09, February 7, 1991, referencing ACWDLs 90-02, 90-29, 90-71 and 90-73.

432-3
For qualified Medicare beneficiaries (QMBs), the CDHS shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the Social Security Act, when the person's income does not exceed the federal poverty level, and resources do not exceed 200% of the SSI Program standard. (Welfare and Institutions Code (W&IC) §14005.11) CDHS shall also pay applicable additional premiums, deductibles, and coinsurance for drug coverage, as offered to categorically needy recipients, as defined in W&IC §14050.1 and Title XIX of the Social Security Act. (W&IC §14005.11(b))

432-4 REVISED 12/05
The four QMB requirements are:

1. A QMB must be eligible for Medicare Part A (Hospital Insurance)

2. A QMB must have income less than 100% of the federal poverty level.

3. A QMB must have property valued at $4000 or less if a single person, or $6000 or less if married and living with a spouse.

4. A QMB must meet certain other Medi-Cal program requirements, such as California residency.

(All-County Welfare Directors Letter (ACWDL) No. 97-34, August 5,1997)

433-1
A Specified Low-Income Medicare Beneficiary (SLMB) is ineligible as a Qualified Medicare Beneficiary (QMB) solely due to excess income.

A SLMB must be entitled to Part A Medicare hospital insurance benefits, meet the qualifying income level as defined in §50570(b), and meet the qualifying resource limit as defined in §50421.

The period of eligibility shall include the first month eligibility is approved, and may include three months of retroactive benefits from the month of application. If eligibility exists, the CDHS shall pay Medicare Part B premiums as defined in §50091.5. (§50258.1)

433-3
The CDHS policy on the Specified Low-Income Medicare Beneficiary (SLMB) Program, established under Public Law 101-508 (§4501 of OBRA, 1990) requires counties to phase in payments for certain Medicare beneficiaries beginning January 1, 1993. A SLMB must be entitled to Medicare Part A, have no more than twice Medi-Cal's property limit, have income below 120% of the federal poverty level (FPL) in 1996 and thereafter, and be a citizen or alien who would be eligible for full Medi-Cal benefits. (All-County Welfare Directors Letter No. 92-61, October 23, 1992; Medi-Cal Eligibility Procedures Manual §5J-1)

A SLMB is ineligible as a QMB solely due to excess income. The CDHS shall pay Medicare Part B premiums for SLMB as defined in §50091.5. (§50258.1)

433-4
The Specified Low-Income Beneficiary (SLMB) Program is limited to the payment of the Medicare Part B premium. It does not pay the Medicare Part A premium or the Part B deductibles or coinsurance. The SLMB's Medicare Part B premium will be purchased under the State Buy-In process.

To be eligible a SLMB must:

- Be entitled to Medicare Part A and B;

- Have no more than twice the Medi-Cal property limit ($4,000 for one person, $6,000 for a couple);

- Have income below 120 percent of the Federal Poverty Level (FPL); and

- Be a citizen or alien who would be eligible for full-scope Medi-Cal benefits if he or she were eligible for a regular Medi-Cal program, except for excess income or property.

A SLMB who meets the Medi-Cal eligibility requirements for a different Medi-Cal program may receive benefits under both programs (SLMB and Medi-Cal) in the same month.

Scope of Medicare Part B Benefits

Medicare Part B medical insurance includes doctor's services, outpatient hospital care, home health care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies.

(Medi-Cal Eligibility Procedures Manual §5J-1)d

433-7
Two new Specified Low-Income Beneficiary (SLMB) programs were authorized by §4732 of the Balanced Budget Act of 1997 (Public Law No. 105-33).

The first group, whose income is between 120% and 135% of the Federal Poverty Level (FPL), is eligible for reimbursement of its Medicare Part B premiums, retroactive to

January 1, 1998.

The second group, whose income is between 135% and 175% of the FPL, is eligible for payment of the Home Health Care portion of Medicare Part A that was transferred to Medicare Part B, retroactive to January 1, 1998.

Neither group is eligible for any other medical program, nor will either group receive Medi-Cal cards.

Both groups have a resource limit of $4000 for a single individual and $6000 for a couple.

(All-County Welfare Directors Letter No. 97-45, November 17, 1997)

434-1 REVISED 11/05
To be eligible for the TB program, a person must:

1. Be infected with TB, as certified by a Medi-Cal physician.

2. Not be a Medi-Cal beneficiary whose coverage is mandated by federal laws, such as AFDC, SSI/SSP, other Public Assistance (PA) or one of the federal poverty level programs.

3. Be a United States citizen or a person who has satisfactory immigration status (SIS).

4. Have income and resources which do not exceed the maximum amount for a disabled individual under the SSI program.

   Income cannot exceed the "TB income standard."

   Property cannot exceed $2,000 for an individual or for a couple, except when determining a child's eligibility, with two parents, in which case it is $3000.

5. Meet all other Medi-Cal requirements, such as cooperation, verification, and status reporting.

(Medi-Cal Eligibility Procedures Manual (MEPM) §5N-1 - 5N-6; All-County Welfare Directors Letters (ACWDLs) No. 95-12, February 10, 1995; 95-39, July 14, 1995, and 95-73, November 22, 1995, and 98-02 (superseding 97-52), January 5, 1998; 99-62, November 24, 1999; 01-03, January 8, 2001)

434-2 REVISED 11/05
In determining net income in the TB program, Medi-Cal regulations governing disabled persons are used to determine deductions and exemptions.

There are three exceptions to this general rule: (1) Parental allocation to ineligible children; (2) parental deduction; (3) non-deeming by certain ineligible spouses.

If the net nonexempt income exceeds the appropriate TB income standard, the individual person is ineligible for the TB program. (MEPM §5N-4, 5)

434-3
The TB resource limit is $2,000 for a single person or for a married couple. These limits increase to $3,000 if the couple's child lives in the home.

Resources are determined under Medi-Cal regulations, except if the TB applicant is a child there are special deeming rules. (MEPM §5N-5, 6; All-County Welfare Directors Letter (ACWDL) No. 95-39, July 14, 1995)

The value of resources are determined as of 12:01 a.m. on the first day of the month. (All-County Welfare Directors Letter No. 95-12, February 10, 1995, Question 20, citing 20 CFR §416.1207)

434-4
In the TB program, the scope of benefits is limited to TB-related services such as physician specified clinics, out-patient hospital services, clinic services, federally qualified health center services, case management services, and services (other than room and board) to monitor prescribed drugs. (MEPM §5N-6, 7)

If a TB infected person is eligible for full-scope Medi-Cal with an SOC, that person should be evaluated for the TB program as that person could be eligible for the TB program and not have an SOC for out-patient TB services, (All-County Welfare Directors Letter No. 95-12, February 10, 1995, Question 11)

435-1
EPSDT supplemental services means health care, diagnostic services, and other treatment that:

(1) Are identified in 42 United States Code §1396d(r).

(2) Are available only to persons under 21 years old.

(3) Meet any medical necessity standard set forth in §51340(e), paragraph (1), (2) or (3).

(4) Are not EPSDT diagnosis and treatment services (as defined in §51184(b)).

(§51184(c))

435-2
Requests for prior authorization for EPSDT supplemental services shall include the following information:

(1) The principal diagnosis and significant associated diagnoses.

(2) Prognosis.

(3) Date of onset of the illness or condition, and etiology, if known.

(4) Clinical significance or functional impairment caused by the illness or condition.

(5) Specific types of services to be rendered by each discipline associated with the total treatment plan.

(6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.

(7) The extent to which health care services have been previously provided to address the illness or condition and results demonstrated by prior care.

(8) Any other documentation available which may assist in making the required determinations.

(§51340(d))

435-3
Orthodontic services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries are covered only when medically necessary pursuant to the criteria set forth in the Medi-cal "Manual of Criteria for Medi-Cal Authorization", Chapter 8.1, as incorporated by reference in §51003(e), or when medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions or defects, pursuant to criteria in §51340(e)(1) or (e)(3). (§51340.1(a)(2))

435-4
The CDHS issued the following interpretation in regard to the EPSDT program:

> The EPSDT program is a federally mandated benefit for full-scope Medi-Cal eligibles under 21 years of age (per the Omnibus Budget Reconciliation Act of 1989 [OBRA '89]).

> Federal Medicaid law requires that states provide medically necessary screening, vision, hearing, and dental services to Medi-Cal beneficiaries under 21 years of age. Additionally, any service a state is permitted to cover that is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by EPSDT screening, must be provided to beneficiaries under 21 years of age whether or not the service or item is otherwise included in the State's Medicaid plan.

MEDICAL NECESSITY UNDER EPSDT:

Overall, there are three ways in which EPSDT supplemental services may be determined medically necessary:

1. The requested EPSDT supplemental service can meet the existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population.

2. The requested EPSDT supplemental service can meet distinct, EPSDT service specific requirements as set forth in §51340.1.

3. If the criteria of 1. above cannot be met, and if the criteria of number 2 above are not applicable to the service, then the requested EPSDT supplemental service must be evaluated under the expanded medical necessity criteria established in the EPSDT regulations in §51340(e)(3), as summarized below:

   A. The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

   B. The supplies, items, or equipment to be provided are medical in nature.

   C. The services are not requested solely for the convenience of the beneficiary, family, physician, or another provider of services.

   D. The services are not unsafe for the individual EPSDT-eligible beneficiary, and are not experimental.

   E. The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary's appearance.

   F. Where alternative medically accepted modes of treatment are available, the services are most cost-effective.

   G. The services to be provided:

      (1) Are generally accepted by the professional medical and dental communities as effective and proven treatments for the conditions for which they are proposed to be used.

      (2) Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the beneficiary.

   H. Available scientific evidence, as described immediately above, demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.

   I. The predicted beneficial outcome of the services outweighs potential harmful effects.

(All-County Letter (ACL) No. 00-83, December 7, 2000, Attachment 3)

435-5
According to the CDHS, in order to fulfill partial requirements of the final judgment and permanent injunction in the case of *Emily Q. et al.* v. *Diana Bontá*, USDC, Central District of California, the new EPSDT Mental Health Services General Information Notice (MC 003) was distributed through a special mailing to all Medi-Cal beneficiaries. To complete the requirements, counties must begin informing new beneficiaries of the EPSDT services at the time of application, and annually thereafter.

Commencing August 8, 2001 the MC 003 notice was required to be distributed to new Medi-Cal applicants at the same time as other required informational forms and handouts. Because all Medi-Cal beneficiary households with children were informed of the EPSDT Mental Health Services via a special mailing in March 2001, counties will not be required to distribute the MC 003 notice at yearly renewal until April 1, 2002.

(All-County Welfare Directors Letter No. 01-47, August 20, 2001)

436-1
Health care, under state law, shall include the following mental health services:

(a) Mental health services provided by a city or county.

(b) Mental health services provided in a Short-Doyle community mental health service or in a community mental health center organized under the Federal Community Mental Health Centers Act of 1963.

(c) Certain outpatient drug abuse services under the jurisdiction of the State Department of Alcohol and Drug Programs, provided by certified private or county providers.

(d) Inpatient hospital services in an institution for mental disease to persons of all ages, provided that such institution is certified as a psychiatric hospital under Title XVIII of the Social Security Act.

(e) Other diagnostic, screening, preventive, or remedial rehabilitative services designed to restore the individual to the best possible functional level, recommended by a physician or licensed practitioner of the healing arts, and provided in a facility, home, or other setting.

(W&IC §14021)

436-2
The CDHS shall add case management services as a benefit under the Short-Doyle Medi-Cal program for persons served by the State Department of Mental Health and Short-Doyle mental health programs. (W&IC §14021.3)

436-3
Community mental health services, as defined in §51341(b), provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program. (§51341(a))

"Community mental health services" include acute inpatient hospital services, psychiatric health facility services, mental health services, medication support, day treatment intensive service, day rehabilitation service, adult and crisis residential treatment services, crisis intervention, and crisis stabilization-emergency room or urgent care. (§51341(b))

436-4
Short-Doyle drug Medi-Cal substance abuse services, as defined in §§51341.1(b)-(d), provided to Medi-Cal beneficiaries, are covered by the Medi-Cal program when determined medically necessary under §51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in §51159. (§51341.1(a))

437-1
The Balanced Budget Act of 1997 established a new Medi-Cal program which pays some or all of the Medicare Part B premium for those eligible to the Qualifying Individuals (QI) program. The QI program is divided into the QI-1 and QI-2 programs.

If an individual has income under 100% of the Federal Poverty Level (FPL) and meets other eligibility criteria such as residency and resource limits, the individual is eligible under the QMB program.

If an otherwise eligible individual has income between 100% and 120% of the FPL, the individual is eligible for the SLMB program.

If an otherwise eligible individual has income of at least 120% but less than 135% of the FPL, the individual is eligible under the QI-1 program. The QI-1 program will pay the full Part B Medicare premium. The QI-1 program, scheduled to sunset effective December 31, 2002, has been continued until at least March 13, 2003. It will "sunset" effective September 31 [sic] 2003.

If an otherwise eligible individual has income in excess of 135% but less than 175% of the FPL, the individual is eligible under the QI-2 program. The QI-2 program reimburses once a year a portion of all monthly Part B premiums which an individual paid during months in the prior year. The QI-2 program was discontinued (i.e., sunsetted) effective December 31, 2002.

The resources limit for the QMB, SLMB and the QI programs is $4000 for an individual and $6000 for a couple.

(All-County Welfare Directors Letter (ACWDL) No. 98-47, October 22, 1998, referencing ACWDLs 97-45 and 98-15; ACWDL No. 03-02, January 15, 2003; ACWDL 03-20, April 22, 2003)

437-3
Counties must review medically needy applications and eligibility redeterminations to determine if there is eligibility for the Qualified Medicare Beneficiary (QMB) program. If the individual is not eligible as a QMB due to income, counties must evaluate the individual for either the Specified Low Income Medicare Beneficiary (SLMB) or the Qualified Individual (QI) program, so that the CDHS can claim funding for the state payment of Medicare Part B payments. While federal law prohibits a QI from being

eligible fro any other Medicaid program, medically needy individuals with an SOC may be eligible for QI in those months the SOC is not met. (All-County Welfare Directors Letters No. 99-61, November 17, 1999)

437-4
The QI-1 Program is limited to the payment of the Medicare Part B premium. It does not pay the Medicare Part A premium, or the Part B deductibles or copayments.

To be eligible a QI-1 must:

- Be entitled to Medicare Part B (which includes doctor's services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and other health services and supplies);

- have income at or above 120 percent of the Federal Poverty Level (FPL) and up to but not including 135 percent of the FPL;

- have no more than twice the Medi-Cal's property limit ($4,000 for one person, $6,000 for a couple); and

- be a citizen or alien who would be eligible for a regular Medi-Cal program except for excess income or property.

QI-1, Other Medi-Cal Coverage:

1. An individual may not be determined eligible for the QI-1 program if he or she is eligible for any other zero SOC Medi-Cal program, such as SSI cash-based Medi-Cal, or ABD-MN with no Share of Cost (SOC).

2. A QI-1 with an SOC is not considered eligible for the SOC program until the SOC is met. Therefore, the QI-1 may be reported to MEDS in both the QI-1 and the SOC aid code in the same month.

(Medi-Cal Eligibility Procedures Manual §5J-5(B.1))

437-4A REVISED 12/05
The QI-1 program provides the state payment of the Medicare Part B premium for individuals with income below 135 percent of the federal poverty level. The QI-1 program was scheduled to sunset on December 31, 2002. That sunset date has been extended several times.

The QI-1 program sunset date has again been extended, this time to September 30, 2007. Counties are to continue accepting applications and determining eligibility for the QI-1 program until the DHS notifies them that the QI-1 program has been discontinued.

(ACWDL 05-37, November 3, 2005)

438-1
Effective January 1, 2001, the State has established an Aged and Disabled Federal Poverty Level (A&D FPL) Program which will provide zero Share of Cost Medi-Cal

benefits to those person who qualify. The basics of the program, are as follows:

- Qualified individuals/couples need to be aged or disabled and not in Long-Term Care.

- Eligibility of qualified individuals will be determined using the income and property medically needy rules.

-- If qualified individuals have other family members applying for Medi-Cal benefits, qualified members will be ineligible member(s) of the other family member's Medi-Cal Family Budget Unit (MFBU). All ineligible family member's income will be used and be considered a part of the MFBU for purposes of determining the maintenance need size.

- Blind applicants or beneficiaries (under Title XVI or XIX) will be referred to the State Programs--Disability in order to determine if they meet disability criteria.

- January Social Security Cost -of-Living Allowance increases should be temporarily disregarded until the effective FPL increases are issued (generally in April).

- Disabled individuals in the A&D FPL program are not subject to an age limitation and as such children who are disabled need to be evaluated for this program.

(All-County Welfare Directors Letters (ACWDLs) No. 00-57, November 14, 2000; 00-68, December 29, 2000; and 02-38, June 28, 2002)

438-2
In determining eligibility for the A&D FPL Program, count the income of the applicant and the applicant's spouse. When the applicant is a "child", count the child's income and the income of the parent. If there is one parent and a child eligible for the program, treat each person as an individual, and not as a single unit. (All-County Welfare Directors Letter No. 01-18, March 16, 2001)

438-3
The law which authorized the aged and disabled federal poverty level (FPL) program provides, in pertinent part, the following:

(c) An aged or disabled individual shall satisfy the financial eligibility requirement of this program if both the following conditions are met:

(1) Countable income, as determined in accord with (42 United States Code (USC) §1396a(m)) does not exceed an income standard equal to 100 percent of the applicable federal poverty level, plus $230 for an individual or, in the case of a couple, $310, provided that the income standard so determined shall not be less than the SSI/SSP payment level for a disabled individual or, in the case of a couple, the SSI/SSP payment level for a disabled couple.

(2) Countable resources, as determined in accord with 42 USC §1396a(m) do not exceed the maximum levels established in that section.

(d) The financial eligibility requirements provided in subdivisions (c) may be adjusted upwards to reflect the cost of living in California, contingent upon appropriation in the annual Budget Act.

(f) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the Social Security Act (42 USC §401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income standard described in subdivision (c).

(g) Notwithstanding any other provision of law, the program provided for pursuant to this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available.

(h) Subject to subdivision (g), this section shall be implemented commencing January 1, 2001.

(W&IC §14005.40)

438-4
It is the position of the CDHS that IHSS deductions (per §50245) are not allowable in the A&D FPL program. (All-County Welfare Directors Letters No. 02-22, April 12, 2002, and 02-22E, May 7, 2002 referencing §50551.6)

438-4A
Health care premiums, and all other medically needy deductions are allowable deductions in the A&D FPL program, except for the IHSS deduction. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

438-5 REVISED 11/05
State law (W&IC §14005.40(c)(1)) requires that the A&D FPL couple's income standard be no less than the Supplemental Security Income/State Supplemental Program (SSI/SSP) couple payment standard. The amount of the A&D disregard can be adjusted to make the A&D FPL couple's income standard equal to the SSI/SSP couple payment standard.

(All-County Welfare Directors Letter No. 02-24, April 30, 2002 and 02-24E, June 10, 2002)

438-6
The A&D FPL program is not a Public Assistance (PA) program. Individuals participating in the program are neither PA nor other PA. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

438-7
It is the position of the CDHS that once the State has begun its "buy-in", a Medi-Cal beneficiary cannot pay his/her own Medicare Part B premium in order to qualify for the A&D FPL program. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

438-8
If both spouses are eligible for the A&D FPL program, they both will receive benefits under that program. If both spouses cannot qualify as a couple, the couple may apply for one or the other if one can qualify this way. The other spouse may be eligible for Medically Needy benefits, or decline to apply for Medi-Cal benefits. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

439-1 ADDED 12/05
The CSRA was $92,760 in 2004, $95,100 in 2005 and is $99,540 in 2006. All-County Welfare Directors Letters (ACWDLs) No. 03-54, 04-36 and 05-40)

439-1A ADDED 12/05
In California, the basic MMMNA was $2319 effective January 1, 2004, $2378 effective January 1, 2005 and is $2489 effective January 1, 2006) (All-County Welfare Directors Letters No. 03-54, 04-36 and 05-40)

439-1B ADDED 12/05
Effective _____, the CSRA was _____. Effective _____, the MMMNA was _____. (ACWDL _____)

439-1C ADDED 12/05
Effective July 1, 2004 through June 30, 2005, the family member maximum base allocation amount for a family member living with the community spouse of a beneficiary with LTC status is $1562. . Effective July 1, 2005 through June 30, 2006, the family member maximum base allocation is $1604. (All County Welfare Director's Letter 04-22, May 21, 2004; ACWDL 05-20, June 14, 2005)

439-1D ADDED 12/05
Effective July 1, ____ through June 30, ____, the family member maximum base allocation amount for a family member living with the community spouse of a beneficiary with LTC status is $____. (All County Welfare Director's Letter _____)

439-2 REVISED 12/05
The "Supplemental Security Income Standard Allocation" and the "Parent Allocation" amounts are to be used in various programs, such as the 250 Percent Working Disabled and QMB/SLM/QI programs.

These allocations are based on the annual federal benefit rate (FBR) which is based on the Cost of Living Adjustment (COLA). The Standard Allocation was $282 in 2004, $290 in 2005 and $301 in 2006 (the couple FBR minus the individual FBR). The Parent Allocation is determined as follows:

When there is earned, unearned income, or a combination of income:

> The parent allocation (if one ineligible parent lives with child) was $564 in 2004, $579 in 2005 and $603 in 2006 (FBR for an individual); and

> The parent allocation (if both ineligible parents live with the child) was $846 in 2004, $869 in 2005 and $904 in 2006 (FBR for a couple).

The Medicare Part A premium was $343 in 2004. It is $375 in 2005 and $393 in 2006. The reduced Medicare Part A premium was $189 for persons with 30 - 39 quarters of Medicare covered employment in 2004, $206 in 2005 and $216 in 2006. Both have a 10 percent penalty for late enrollment.

The Part A deductible was $876 in 2004, $912 in 2005 and $952 in 2006 for the first 60 days. For the 61st to 90th day it was $219 in 2004, $228 in 2005 and $238 in 2006. For days 91 through 150, the deductible was $438 in 2004, $456 in 2005 and $476 in 2006. The skilled nursing facility deductible was $109.50 in 2004 and $114 in 2005 for the 21st through 100th day (there is no deductible for day 1 through 20).

The Medicare Part B premium was $66.60 in 2004, $78.20 in 2005 and $88.50. The deductible was $100 until 2005 when it increased to $110. It increased to $124 in 2006

Disregard the Title II COLA for all programs where eligibility is based on the federal poverty level (FPL) except the Qualified Disabled Working Individuals program until the new FPLs are in effect on April 1. These programs include the Income Disregard program, 133 Percent, and 100 Percent programs for children, the 250 Percent Working Disabled, the 1931(b) program, the Aged and Disabled FPL program and the QMB/SLMB/QI programs.

(All-County Welfare Directors Letters No. 03-57, November 26, 2003, 04-39 December 29, 2004 and 05-38, November 10, 2005))

439-3 REVISED 3/06
In the TB program, the income standard for an individual effective January 2005 is $1243 and effective January 1, 2006 is $1291. The standard allocation effective 2005 is $290 and 2006 is $301. The federal benefit rate (FBR) used to determine the parental deduction is $579 for an individual in 2005 and $603 in 2006. The FBR for a couple in 2005 is $869 and for 2006 is $904.

The resource limit is $2000. If the applicant is married when determining eligibility, use only the applicant's separate property and one-half of the community property.

When determining a child's eligibility and there is one parent present, allow the parent a $2000 property limit; if both parents are present allow $3000 for the parents

(ACWDL 05-01, January 25, 2005; ACWDL 06-01 January 23, 2006)

439-3A
In the TB program, the income standard for an individual effective _____ is $____. The standard allocation is $___. The federal benefit rate used to determine the parental deduction is $____ for an individual and $___ for a couple. (ACWDL _____)

439-4 REVISED 12/05
The Medicare Part B premium was $66.60 in 2004, $78.20 in 2005 and $88.50 in 2006. (All-County Welfare Directors Letters No. 03-57, November 26, 2003, 04-39, December 29, 2004and 05-38 November 10, 2005)

439-4A ADDED 12/05
The Medicare Part B Premium is _____ effective _____. (ACWDL _____)

439-5 REVISED 3/06
The effective income limit for an A&D FPL individual is $1028 effective April 1, 2005 ($798 FPL + $230 income disregard). The effective income limit for an A&D FPL individual is $1047 effective April 1, 2006 ($817 FPL + $230 income disregard).

The effective income limit for an A&D FPL couple is $1422 effective January 2005 through March 2005. ($1041 FPL effective April 1, 2004 + $381 income disregard)

The effective income limit for an A&D FPL couple is $1437 effective April 1, 2005 through March 2006. ($1070 FPL effective April 1, 2005 + $367 income disregard)

The effective income limit for an A&D FPL couple is $1472 effective April 1, 2006. ($1100 FPL effective April 1, 2005 + $372 income disregard)

(All County Welfare Director's Letter 05-15, April 7, 2005, ACWDL 06-08, February 15, 2006)

439-5A
The effective income limit for an A&D FPL individual is $_____ effective April 1, 20__ ($___ FPL + $230 income disregard).

The effective income limit for an A&D FPL couple is $____ effective _____ 20__ through _____ 20__ ($____ FPL effective April 1, ____ + $___ income disregard).

(ACWDL ____)

439-6 REVISED 12/05
The Specified Low-Income Medicare Beneficiary (SLMB) income limit has been 120% of the FPL since 1996. The ____ SLMB income level is

Persons	Income Level
1	$____
2	$____

The SLMB resource level is $4,000 for a single individual and $6,000 for a couple.

(All-County Welfare Directors Letter (ACWDL) No. 97-34, August 5, 1997; ACWDL No. _____)

439-6A ADDED 12/05
The Qualified Medicare Beneficiary (QMB) income limit has been 100% of the FPL since 1996. (All-County Welfare Directors Letter (ACWDL) No. 97-34, August 5, 1997)

439-7
REVISED 3/06
The Federal Poverty Level (FPL) effective April 1, 2005 for one person is $798 and $817 effective April 1, 2006. The FPL for two persons is $1070 effective April 1, 2005 and $1100 effective April 1, 2006.

The SLMB income level (120% of the FPL) for one person is $957 and for two persons is $1283 effective April 1, 2005. The SLMB level for one person is $980 and for two persons is $1320 effective April 1, 2006.

The QI income level (135% of the FPL) is $1077 for one person and $1444 for two persons effective April 1, 2005. The QI income level is $1103 for one person and $1485 for two persons effective April 1, 2006.

(ACWDL 05-12, March 7, 2005, ACWDL 06-06, February 10, 2006)

439-7A ADDED 12/05
The FPL effective _____ is _____ (ACWDL _____)